



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Doctors Hospital at Renaissance

**Respondent Name**

Liberty Mutual Insurance Co

**MFDR Tracking Number**

M4-17-1190-01

**Carrier's Austin Representative**

Box Number 1

**MFDR Date Received**

January 3, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

**Amount in Dispute:** \$378.75

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The provider is requesting reimbursement for physical therapy at according to the OPPS reimbursement formula. Attached is a copy of the rules form 28 TAC 134.403 regarding reimbursement for services, such as physical therapy, which are not addressed by OPPS. These are reimbursed according to Medicare and Fee Schedule Guidelines in effect for those services. The OPPS Payment system and reimbursement formula do not apply."

**Response Submitted by:** Liberty Mutual Insurance

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 19 – 25, 2016	Physical therapy performed in outpatient hospital	\$378.75	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 provides reimbursement guidelines for hospital facility fee guideline—outpatient.
3. 28 Texas Administrative Code §134.203 provides medical fee guideline for professional services
4. 28 Texas Administrative Code §134.600 sets out requirements for prior authorization.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- Z710 – The charge for this procedure exceeds the fee schedule allowance
  - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
  - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered
  - X388 – Pre authorization was requested but denied for this service per DWC Rule 134.600
  - W3 – The charge for this procedure exceeds the fee sch
  - X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due

### **Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule applies to reimbursement?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The requestor is seeking additional reimbursement of \$378.75 for physical therapy services performed in an outpatient hospital setting from May 19 – 25, 2016.

The insurance carrier denied disputed service code 97035 with claim adjustment reason code 388 – “Pre-authorization was requested but denied for this service per DWC Rule 134.600.”

28 Texas Administrative Code §134.600 (p) states in pertinent part,

Non-emergency health care requiring preauthorization includes:

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning;

Review of the submitted information found no documentation from the requestor to indicate compliance with Rule 134.600(p)(5)(A) in obtaining prior authorization. Therefore, the carrier's denial is upheld.

The remaining codes listed on the DWC60 received a payment but the requestor is requesting additional payment. The applicable fee guideline and reimbursement amounts are found below.

2. As these services were submitted with type of bill “131” or Hospital, Outpatient, Admit through discharge claim, 28 Texas Administrative Code §134.403 (h) hospital facility fee guideline—outpatient applies and states,

For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

The codes that remain in dispute are defined as:

- 97140 – Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
- 97112 – Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

- 97110 – Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

These codes have a status indicator of “A” which is defined as “Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, Not paid under OPPS. Paid by MACS under a fee schedule or payment system other than OPPS.”

Therefore, these services will be reviewed per applicable fee guideline that applies to professional services.

3. 28 Texas Administrative Code §134.203 establishes the medical fee guideline for professional services. The relevant section that pertains to physical therapy states,

(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor.)

The calculation of the maximum allowable reimbursement is as follows:

- The formula to calculate the maximum allowable reimbursement is:  $\text{DWC Conversion Factor} / \text{Medicare Conversion Factor} \times \text{Fee schedule amount} = \text{TX FEE MAR}$ .
  - Procedure code 97140, date of service May 19, 2016. The Medicare Physician Fee Schedule amount for this code is \$28.87. This amount divided by the Medicare conversion factor of 35.8043 and multiplied by the Division conversion factor of 56.82 yields a MAR of \$45.81.
  - Procedure code 97112, date of service May 19, 2016. The Medicare Physician Fee Schedule amount for this code is \$32.51. This amount multiplied by 2 units is \$65.02. This amount divided by the Medicare conversion factor of 35.8043 and multiplied by the Division conversion factor of 56.82 yields a MAR of \$103.18.
  - Procedure code 97140, date of service May 23, 2016. The Medicare Physician Fee Schedule amount for this code is \$28.87. This amount divided by the Medicare conversion factor of 35.8043 and multiplied by the Division conversion factor of 56.82 yields a MAR of \$45.81.
  - Procedure code 97112, date of service May 23, 2016. The Medicare Physician Fee Schedule amount for this code is \$32.51. This amount divided by the Medicare conversion factor of 35.8043 and multiplied by the Division conversion factor of 56.82 yields a MAR of \$51.59.
  - Procedure code 97110, date of service May 23, 2016. The Medicare Physician Fee Schedule amount for this code is \$31.19. This amount divided by the Medicare conversion factor of 35.8043 and multiplied by the Division conversion factor of 56.82 yields a MAR of \$49.49.
  - Procedure code 97140, date of service May 25, 2016. The Medicare Physician Fee Schedule amount for this code is \$28.87. This amount divided by the Medicare conversion factor of 35.8043 and multiplied by the Division conversion factor of 56.82 yields a MAR of \$45.81.
  - Procedure code 97112, date of service May 25, 2016. The Medicare Physician Fee Schedule amount for this code is \$32.51. This amount divided by the Medicare conversion factor of 35.8043 and multiplied by the Division conversion factor of 56.82 yields a MAR of \$51.59.
- 4. The total allowable reimbursement for the services in dispute is \$393.28. This amount less the amount previously paid by the insurance carrier of \$393.29 leaves an amount due to the requestor of \$0.00. No additional reimbursement recommended.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

### Authorized Signature

_____	_____	January 30, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

### YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**